

## **Licensed Practical Nurse by Examination Trained inside United States Application Packet**

### **Contents:**

1. 669-226 ...Contents List/SSN Information/ Mailing Information ..... 1 page
2. 669-261 ...Application Instructions Checklist .....2 pages
3. 669-227 ...License Requirements ..... 1 page
4. 669-002 ...Licensed Practical Nurse Application .....5 pages
5. 669-239 ...Out-of-State Nurse Program Certificate of Completion..... 1 page
6. RCW/WAC and Online Web Site Links ..... 1 page

### **Important Social Security Number Information:**

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number, please read, complete, and return this [form](#) with your application.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

### **In order to process your request:**

**Mail your application with initial  
documentation and your check  
or money order payable to:**

Department of Health  
PO Box 1099  
Olympia, WA 98507-1099

**Send other documents not sent  
with initial application to:**

Nursing Commission  
PO Box 47864  
Olympia, WA 98504-7864

### **Contact us:**

360.236.5703

(This page intentionally left blank.)

## Application Instructions Checklist

**FBI background check information:** Washington State Law authorizes the Department of Health to obtain fingerprint background checks for licensing purposes. This check is done through the Washington State Patrol and the Federal Bureau of Investigation (FBI).

- You **will** be required to submit fingerprints for the background check if you have an out of state address listed on this application. (Not out of country).
- You **must** obtain your fingerprints on the Department of Health fingerprint card.
- Once we receive your application **we will send** you the fingerprint packet with instructions on how to complete the process.
- A temporary practice permit will be issued if all other licensing requirements are met pending the completion of this process.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the required forms.

☐ **Application Fee.** This fee is non-refundable. You can check the online [fee page](#) for current fees.

☐ **1. Demographic Information:**

**Social Security Number:** You must list your social security number on your application. If you do not have a social security number please read, complete, and return this [form](#) with your application.

**Legal Name:** List your full name: first, middle and, last.

**Definition of legal name:** "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

**Birth date:** Provide the month, day and year of your birth.

**Birth place:** Provide the city, state and country where you were born.

**Address:** List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

**Phone, Fax and Cell Numbers:** Enter your phone, fax and cell numbers, if you have them.

**Email:** Enter your email address. Email is our primary form of communication. Join our [Listserv](#).

**Other Name(s):** Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

☐ **2. Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Professional Education:**

List your current or completed nurse program. Indicate degree/certificate/diploma earned. List graduation or anticipated graduation date. Attach additional completed pages if you need more space.

☐ **4. License in Other State(s) or Country(ies)**

List all states/countries where you have held an RN or an LPN license. Indicate method of licensure by examination or endorsement.

☐ **5. AIDS Education and Training Attestation:**

Read the AIDS education and training attestation. AIDS training may include self-study, courses, or formal training. If you feel that you have met the requirements on the application, or if your nursing education was after 1991, you can initial and date this section without any further training. Course content can be found in [WAC 246-12-270](#).

☐ **6. Applicant’s Attestation:**

You must sign and date your application for it to be valid. Your signature indicates that you have read and understood this section.

Please note: You will be notified in writing if more documentation is needed. Please try to avoid calling to check on the status of your application. This will allow program staff to process your application file with fewer interruptions.

- The application is incomplete if requested information is left blank. Fill in N/A or place a line through section instead of leaving blank.
- The initial license will expire on your birthday unless the license is issued within 90 days of your next birthday. See [WAC 246-12-020\(3\)](#).
- Please review [continued competency requirements](#) for renewal.

## **Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington**

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at [the military resources page](#) and include supporting documentation with your application.

## **License Requirements LPN Educated Inside the United States**

Thank you for applying to become a Licensed Practical Nurse in Washington State.

### **1. Certificate of Completion**

If you are a graduate of a Washington State nursing program, the director of the program will send an electronic certificate of completion to our office after you complete the program. We can make you eligible to take the NCLEX once we receive it.

If you are a graduate from a nursing program in another US State or jurisdiction, submit the paper certification of completion that is in this packet to your program director. Have them fill it out and submit to the Nursing Commission.

### **2. Official Transcripts:**

Have your school of nursing mail your transcripts with the **degree listed** to the Nursing Commission. We need the official transcripts to license you after you pass your NCLEX.

### **3. NCLEX:**

Once you graduate and send your application to the Nursing Commission you need to go to [www.pearsonvue.com](http://www.pearsonvue.com) and register to take the national exam, NCLEX. Once you register, our office makes you eligible in the Pearsonvue website. Pearsonvue will email you the "authorization to test" (ATT). At that point you can schedule to take the exam. We suggest you use the [NCLEX Candidate Bulletin](#). The candidate bulletin guides you through the registration process with Pearsonvue to take the NCLEX. Pearsonvue is the testing agency that administers the exam.

We receive results 24 hours following your exam. Your license will be issued shortly after. You can access our website to verify your license is issued. You will receive a paper license in the mail 7-10 working days after it is issued. This will be the **only** paper copy you receive. Please use our website to verify license status after that.

(This page intentionally left blank.)

Background  
Check  
Stamp  
Here

Date  
Stamp  
Here

Revenue 0258010000

## Licensed Practical Nurse Application

You must check the box next to Examination or Endorsement: ☐ Examination ☐ Endorsement

### 1. Demographic Information

**Social Security Number** (If you do not have a social security number, see instructions)

☐ Male  
☐ Female

Name First Middle Last

Birth date (mm/dd/yyyy)

#### Place of birth

City

State

Country

Address

City

State

Zip Code

County

Country

Phone (enter 10 digit #)

Fax (enter 10 digit #)

Cell (enter 10 digit #)

Email address:

Mailing address if different from above address of record

City

State

Zip Code

County

Country

**Note:** The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

#### For Office Use Only

☐ COC Received

Review for: ☐ FBI ☐ HIPBB ☐ WSP ☐ PDQ ☐ NOD

☐ Approved per policy A21.05 delegated decision making for selected license applications

☐ Forward to CMT ☐ Approved by CMT ☐ Denied by CMT

☐ Proceed with licensing process

Signature

Date

## 2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation..... ☐ ☐

**“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.
- 1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

**Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. .... ☐ ☐

**“Currently”** means within the past two years.

**“Chemical substances”** include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?..... ☐ ☐
4. Are you currently engaged in the illegal use of controlled substances?..... ☐ ☐

**“Currently”** means within the past two years.

**Illegal use of controlled substances** is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

**Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ... ☐ ☐

**Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.**

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.



## 2. Personal Data Questions (cont.)

Yes No

- a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction ..... ☐ ☐

**Note: If you answered “yes” to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.**

- b. If you answered “yes” to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ..... ☐ ☐
6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ..... ☐ ☐
- b. Diverted controlled substances or legend drugs? ..... ☐ ☐
- c. Violated any drug law? ..... ☐ ☐
- d. Prescribed controlled substances for yourself? ..... ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, please attach an explanation and provide copies of all judgments, decisions, and agreements? ..... ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ..... ☐ ☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ..... ☐ ☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ..... ☐ ☐

## 3. Professional Education

Current or Completed Nursing Program	Name/Location of Nursing Program	Anticipated Graduation Date	Certificate/Diploma/Degree Granted
			<input type="checkbox"/> ADN
			<input type="checkbox"/> BSN
			<input type="checkbox"/> MSN
			<input type="checkbox"/> RN Diploma
			<input type="checkbox"/> PN Cert/dip
			<input type="checkbox"/> Other

#### 4. License(s) in Other State(s) or Country(ies)

List all states/countries you have held a practical nurse license.

Check One		State/Country	Current Expiration Date	Method of Licensure	
As RN	As LPN			Exam	Endorsement

**State or country** in which originally licensed by examination. \_\_\_\_\_

Year license first issued \_\_\_\_\_ as an ☐ RN ☐ LPN

Have you taken the State Board Test Pool Examination (SBTPE) or NCLEX in the United States? ☐ Yes ☐ No

If yes, state \_\_\_\_\_ as an ☐ RN ☐ LPN

Have you ever applied for license in Washington prior to this application? ☐ Yes ☐ No

If yes, under the name of \_\_\_\_\_ as an ☐ RN ☐ LPN Approximate date \_\_\_\_\_

#### 5. AIDS Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues confidentiality, psychosocial issues, and special population considerations.

I understand I must maintain records documenting education for two years and be prepared to submit those records to the department if requested. **I understand if I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

## 6. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the laws of the state of  
(Print applicant name clearly)  
Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated \_\_\_\_\_ in \_\_\_\_\_  
(mm/dd/yyyy) (City, state)

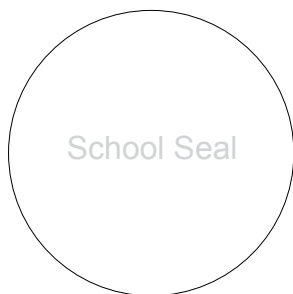
By: \_\_\_\_\_  
(Signature of applicant)

(This page intentionally left blank.)

**Out-of-State Nurse Program  
Certificate of Completion**  
(To be completed after program completion)

I certify the individual listed below **has** completed all requirements for the degree/diploma for the approved Licensed Practical Nurse program as outlined in [WAC 246-840-575](#). I understand my signature on this form will allow this individual to sit for the Licensed Practical Nurse license examination. **An official transcript with the degree/diploma posted will follow as soon as it is available.**

Name of Graduate	
Last	First Middle Name/Initial
Birth Date (mm/dd/yyyy)	Date of program completion (mm/dd/yyyy)
Social Security Number	



\_\_\_\_\_  
Signature of Authorized Person

\_\_\_\_\_  
Title

\_\_\_\_\_  
Name of Nursing School

\_\_\_\_\_  
Date (mm/dd/yyyy)

Please send completed form to the above address.

(This page intentionally left blank.)



## **RCW/WAC and Online Web Site Links**

### **RCW/WAC Links**

Uniform Disciplinary Act .....	<a href="#"><u>UDA RCW 18.130</u></a>
Unprofessional Conduct.....	<a href="#"><u>RCW 18.130.180</u></a>
Administrative Procedure Act .....	<a href="#"><u>APA RCW 34.05</u></a>
Administrative procedures and requirements .....	<a href="#"><u>WAC 246-12</u></a>
Nursing Care Law .....	<a href="#"><u>RCW 18.79</u></a>
Nursing Care Rules .....	<a href="#"><u>WAC 246-840</u></a>

### **On-Line**

AIDS Training Resources .....	<a href="#"><u>Reference Page</u></a>
Nursing Commission .....	<a href="#"><u>Web Page</u></a>